**WELCOME TO EYECARE ASSOCIATES OF SF**

Thank you for choosing **EyeCare Associates of San Francisco** for your eye care needs. Our ophthalmologists, Dr. Kevin Tan, Dr. S. Samuel Gelbart and Dr. Negin Agange as well as our optometrists Dr. Anh Tran, Dr. Ann Nguyen and Dr. Peggy Zeng are happy to share their passion for eye care with you.

Please take the time to read and complete the enclosed forms:

* Confidential contact and health history form
* Financial policy
* Notice of Privacy Practices and Acknowledgement form

These documents provide us with a comprehensive picture of your health status and a greater ability to address your eye health concerns. Please bring your completed forms along with your picture ID and insurance card(s) to your visit. Please use a separate sheet if needed to provide a complete list of current and historical medications. For your convenience we have posted our New Patient forms and Notice of Privacy Procedures on our website at [www.eyecaresf.com](http://www.eyecaresf.com).

**MEDICAL ASPECTS**

Your visit may last 1-3 hours, depending upon the specialized tests or procedures required. Please bring your current medications and your current eyeglasses with you to your appointment. If you have diabetes, please be sure to eat your regular meal or bring a snack.

Before seeing your doctor, you will be evaluated by an ophthalmic technician and/or an optometrist who may need to dilate your pupils. Pupil dilation will make it difficult for you to see at near but your distance vision should be adequate to drive, if you so choose. It may be advisable to bring a driver. We do advise that you bring your sunglasses. The effects of dilation usually wear off in a few hours; however, they may last as long as 24 hours.

**CONFIDENTIAL CONTACT FORM**

**LAST NAME**: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FIRST NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**:\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Ph#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Secondary Ph#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SS# (last 4 #s okay)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_ **Sex:** M/F **Marital Status** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Preferred language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you drive?** Y/N

**EMPLOYER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION**

**What is the best way to communicate with you between office visits?**

(Circle one) E-mail Home Phone Work Phone Mobile Phone

*Is there any place you do NOT want us to leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.*

**Please initial one of the following statements:**

\_\_\_\_\_\_\_ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

\_\_\_\_\_\_\_ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.

\_\_\_\_\_\_ I do not consent to receiving any information via email or text. I understand that I can change my mind and provide consent later.

**Person to contact in case of emergency:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation to patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­**

**Optometrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How were you referred to EyeCare Associates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give EyeCare Associates permission to discuss my health information with the following health care provider(s) and/or family member(s):**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Vision Insurance: VSP MES EYEMED OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient relationship to policy holder:** SELF/SPOUSE/DOMESTIC PARTNER/ PARENT

**Secondary (in applicable):**

**Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient relationship to policy holder:** SELF/SPOUSE/DOMESTIC PARTNER/ PARENT

**Please provide copies of all cards at check-in**

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

**1.** I, the undersigned, realize that all medical and surgical charges incurred are my financial responsibility and hereby authorize ECASF to bill my insurance on my behalf. I hereby authorize the release of medical information to my health and/or vision plan or its intermediaries any information needed for this or related claim. A photocopy of this document shall be as valid as the original. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

**2**. I understand that I am financially responsible to ECASF for deductibles, co-payments, and any services not covered by my insurance(s).

**3**. I acknowledge that I have been given a copy of ECASF Notice of Privacy Practices.

**I HAVE READ THE ABOVE AND AGREE TO ABIDE BY ITS TERMS AND FURTHER ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLY TO ECASF.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**History and Intake Form**

**Past Medical History**: (please circle all that apply)

Anxiety

Arthritis

Artificial joints

Asthma

Atrial fibrillation

BPH

Bone Marrow Transplantation

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

End Stage Renal Disease

GERD

Hearing Loss

Hepatitis

Hypertension

HIV/AIDS

Hypercholesterolemia

Hyperthyroidism

Hypothyroidism

Leukemia

Lung Cancer

Lymphoma

Pacemaker

Prostate Cancer

Radiation Treatment

Seizures

Stroke

Valve Replacement

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**: (please circle all that apply)

Appendix Removed

Bladder Removed

Mastectomy (Right, Left, Bilateral)

Lumpectomy (Right, Left, Bilateral)

Breast Biopsy (Right, Left, Bilateral)

Breast Reduction

Breast Implants

Colectomy: Colon Cancer Resection

Colectomy: Diverticulitis

Colectomy: IBD

Gallbladder Removed

Coronary Artery Bypass

PTCA

Mechanical Valve Replacement

Biological Valve Replacement

Heart Transplant

Joint Replacement, Knee (Right, Left, Bilateral)

Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years

Kidney Biopsy

Kidney Removed (Right, Left)

Kidney Stone Removal

Kidney Transplant

Ovaries Removed: Endometriosis

Ovaries Removed: Cyst

Ovaries Removed: Ovarian Cancer

Prostate Removed: Prostate Cancer

Prostate Biopsy

TURP

Skin Biopsy

Basal Cell Cancer Surgery

Squamous Cell Carcinoma Surgery

Melanoma Surgery

Spleen Removed

Testicles Removed (Right, Left, Bilateral)

Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular History: (please circle all that apply)**

Allergic conjunctivitis

Blepharitis

Cataract (Left eye, Right eye)

Corneal dystrophy (Left eye, Right eye)

Diabetic retinopathy, background (Left eye, Right eye)

Dry eyes

Glaucoma (Left eye, Right eye)

Macular degeneration (Left eye, Right eye)

Macular ERM (Left eye, Right eye)

Narrow angles (Left eye, Right eye)

Ocular hypertension (Left eye, Right eye)

Ophthalmic Migraine

Pseudoexfoliation

Retinal tear (Left eye, Right eye)

Strabismus

PVD (Left eye, Right eye)

Vitrous floaters (Left eye, Right eye)

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular Surgery**: (please circle all that apply)Blepharoplasty (Left eye, Right eye)

Cataract surgery (Left eye, Right eye)

Corneal transplant (Left eye, Right eye)

DSAEK (Left eye, Right eye)

Eye Muscle Surgery

Intravitreal injections (Left eye, Right eye)

LASIK (Left eye, Right eye)

LPI (Left eye, Right eye)

LTP (Left eye, Right eye)

PRK (Left eye, Right eye)

Ptosis repair (Left eye, Right eye)

Punctal plugs (Left eye, Right eye)

Strabismus surgery

Renital laser (Left eye, Right eye)

Trabeculectomy (Left eye, Right eye)

Tube shunt (Left eye, Right eye)

Yag capsulotomy (Left eye, Right eye)

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**: (please circle all that apply)

Blindness

Cancer

Cataracts

CVA

Diabetes

Glaucoma

Heart disease

Macular degeneration

Migraine

Retinal detachment

Strabismus

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: (Please list all current medications)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**None**

**Do you give EyeCare Associates of San Francisco consent to import your medication history as provided by SureScripts: YES / NO**

**Preferred Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies**: (Please enter all allergies)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**None**

**Social History**: (Please circle all that apply)Cigarette Smoking:

Never smoked

Quit: former smoker

Smokes less than daily

Smokes daily

Alcohol Use:

Alcohol: none

Alcohol: less than 1 drink a day

Alcohol: 1-2 drinks a day

Alcohol: 3 or more drinks a day

None

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT FINANCIAL POLICY**

The goal of our practice is to provide a full-range of efficient and quality ophthalmological and optometric care to all our patients. In order to provide comprehensive vision services, we ask that patients provide their medical and vision insurance coverage information at the time of registration and to update us of any changes in coverage and contact information. It is the member’s responsibility to verify eligibility, benefits and provider status.

One important part of your eye exam is the Refraction. The refraction determines your eyeglasses prescription and allows the doctor establish your best visual acuity and gives us vital information as to how your eyes are functioning. Refractive services are billed using a separate procedure code to **VISION INSURANCE PLANS IF AVAILABLE. Refractions are NOT COVERED under Medicare and most medical insurance plans including Brown and Tolland and Hill Physicians.** Unless we have specific proof of coverage, you will be charged a fee of $80.00 for refraction services payable at the time of service.

( ) YES, I WANT A REFRACTION ( ) NO, I DO NOT WANT A REFRACTION

1. Please note that contact lens exam services are NOT considered a routine part of your exam and there are additional fees for these services. Please see additional form provided for a schedule of fees.
2. Medicare beneficiaries are responsible for the yearly Medicare deductible which is $183.00 for 2018. We will also collect 20% of fees for all services provided at the time of service if no secondary coverage is available.
3. Our providers and staff will be happy to provide you or your physician with a copy of your Medical Records and/or to complete any governmental or employer issued forms in a timely fashion. The fee for this service is $25.00 due upon completion.
4. Our office requires a 24 hour cancellation for all appointments. Missing your appointment or not providing us with a 24 hour cancellation notice will result in a $50.00 charge to your account and will be your financial responsibility. Our staff does call as a courtesy reminder, but it is your responsibility to keep your scheduled appointments. Since these appointments times are not able to be utilized by other patients; these fees will NOT be waived.
5. Due to the difficulty and unreliability in collecting fees from out-of state and traveler’s insurance companies we will collect fees for services provided from all patients that are visiting from out of state or out of the country. We will bill your insurance as a courtesy and reimburse you if the services are covered.

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(I have read and understand the above financial policy. I agree to abide by its terms.)